Comments on OSC report by Glen Moseley

1 SUMMARY OF CONCLUSIONS

1.1 ALLEGATION #2 ON PAGE 3

> *"Management's actions or inactions were not, however a factor in the Veteran's original relapse in October."*

I completely disagree with this conclusion and that the allegation should be substantiated fully.

2 WHY I DISAGREE WITH THE FINDINGS FOR ALLEGATION #2

2.1 ON PAGE 6 OF THE REPORT IT STATES IN THE SECTION BEGINNING WITH IN MAY 2014.

> That Jake Mason was made aware of the relationship between the Veteran and Ms. Elsing a VA employee on September 28, 2014. Mr. Mason wrote a note in the Computerized Patient Record System (CPRS) and placed the note in the patient's record and tied Mr. Gordon Aleckson, a member of management to the note. This is the first time management was made aware of the situation.

2.2 FURTHER ON PAGE 6 OF THE REPORT IN THE LAST SECTION BEGINNING WITH ON OCTOBER 15TH;

> *"During the visit, he <u>again</u> spoke to Mr. Mason about the relationship, including identifying Ms. Elsing by name."*

By these statements it is clear that the Veteran has asked for help with the relationship twice. Management could have done something as soon as September 28th but chose not to do so.

2.3 ON PAGE 7 OF THE REPORT IN THE SECTION BEGINNING WITH ON OCTOBER 27TH, THE FINAL SENTENCES OF THAT SECTION STATE;

> *"Ms. Routh pointed out that Ms. Elsing was not detailed form the library at that time since the Veteran was an outpatient and, according to Ms. Elsing, had agreed not to come to the library."*

This is yet another example of management's failure to protect the Veteran from further harm. Management put the onus on the patient to avoid contact with the employee instead of where it belonged, with the employee and management. This decision had the effect of denying the Veteran full access to the Tomah VA facility specifically the library. This is the type of culture that Tomah exhibits toward those whom it is supposed to care for. This type of management decision is why the whistle blowers felt it was necessary to file an OSC complaint. Management took the

employee at her word that she would have no further contact with the Veteran. This is akin to letting the fox guard the henhouse and is absurd when the evidence is clear that the relationship is dangerous to the patient and the employee has demonstrated such poor judgement. At this point no further monitoring or safe guards were implemented to ensure compliance with the no contact order. Management simply believed someone who admitted to an egregious violation of the patient, care giver relationship would suddenly act responsibly.

2.4 On page 7 of the report in the final section

It is very troubling to me that Dr. Berndt ask that a Report of Contact (ROC) be disregarded instead of the person who wrote it. It appears that HR took Dr. Brandt's word for it that DR. Cannon made a mistake. Dr. Cannon should have been the one to inform HR and then ask for his original ROC to be removed. Furthermore, a written request from Dr. Cannon should have been included in the evidence list. Again this is troubling because the ROC was to demonstrate just how negatively this relationship was affecting the patient's ability to concentrate and ultimately recover.

2.5 On page 8 of the report in the section beginning with on November 24TH;

> *"Ms. Young detailed Ms. Elsing to the Sterile Processing Service (SPS)."*

I am highly suspicious of this statement in the report. One of the reasons the whistleblowers filed their complaint is no observable action had taken place until management was made aware of the OSC complaint. That did not occur until December 4th. On December 5th not November 24th Ms. Elsing was removed from the library and assigned to SPS.

2.5.1 The supporting evidence is clearly stated on the same page in the section beginning with Mr. Moseley told;

> *This section states that the patient told Mr. Moseley on December 5th that Ms. Elsing had been reassigned.*

Had this occurred two weeks prior (November 24th) as stated by Ms. Young the patient would have expressed that to me at that time. This changing of dates after the fact implies to me that management is trying to cover up their failure to act.

2.6 On Page 9 the section beginning with between Dec 8 and 12;

Once the letters were submitted and reviewed by HR the termination process should have begun in earnest and Ms. Elsing should have been placed on administrated absence (AA). There is no excuse for allowing Ms. Elsing to continue to come to work at the Tomah VA and continue to harm and distract the veteran from his treatment. This is gross negligence and the Managerial and HR staff should be removed from their positions.

2.7 ON PAGE 9 THE SECTION BEGINNING WITH ON DECEMBER 12TH;

> *Mr. DeSanctis asked Ms. Steinhoff to contact the VISN HR staff (Lusk and Spahos) and ask for guidance on whether Ms. Elsing should be placed on AA.*

This is at best embarrassing and at worst incompetence. How is it that the employee has already admitted to the abuse, broken her word about no contact and the patient provided statements that he will harm himself over this relationship not grounds for immediate removal from the facility?! According to exhibit 20 Ms. Steinhoff gave a brief sysops of the situation to MR. Lusk and Mr. Spahos but it is unreasonable to expect someone without all the information to make the correct judgement call. This decision should have rested squarely with Mr. DeSanctis and Mr. Dechant both of whom have the authority and moral obligation to protect patients from harm and they both failed catastrophically.

2.7.1 On Page 9 the section beginning with Ms. Steinhoff

> *Ms. Steinhoff informs Mr. DeSanctis on December 16th that the VISN HR staff (Lusk) recommended that management not place Ms. Elsing on AA this time. Mr. Lusk did not offer any alternatives to the AA. However, Ms. Steinhoff states that Mr. Lusk wants to "wait and see if the employee complies with the no contact order"*

Clearly Mr. Lusk is not aware that Ms. Elsing has violated every voluntary no contact order or he is simply confused. I find it bizarre that the recommendation from the VISN HR staff is to "wait and see" while the potential for continued harm to the patient by the employee if she does not adhere to the no contact orders.

2.7.2 On page 9 section beginning with on January 22nd.

Further contact is still occurring. Why!? The reason is because management has still failed to take the abuse of a patient seriously and place the employee on AA.

2.7.3 Continuing on page 10 last section

> *HR is still unwilling to place Ms. Elsing on AA. Mr. Dechant has again been asked by Mr. DeSanctis to contact the VISN HR Mr. Lusk to determine if reassigning Ms. Elsing to a CBOC is ok.*

This further strengthens the whistleblowers claim that management is either unwilling or incapable of making a decision with regard to patient safety. It is not until January 26th that Ms. Elsing is finally moved to the furthest building possible from the Veteran and even then HR was reluctant to do so. For whatever reasons the leadership and HR at Tomah was reluctant to act in the patient's best interest. When similar instances have occurred in the past of this type of behavior the employee was removed to AA within 4 days! This further reinforces that HR and management should be held accountable for allowing this abuse to continue for so long.

2.8 On page 11 the first two sections.

Once the decision to terminate Ms. Elsing was made the facility still did not remove the employee to AA. The fact that it took 45 days to terminate Ms. Elsing once the decision had been made to do so is horrendous. This entire length of time, from February 2nd – March 12th Ms. Elsing had the ability to walk the campus and potentially inflict more harm on the patient.

3 Conclusion

I am saddened and shaken that it took 6 months to remove an employee, who by her own admission, had a sexual relationship with a patient. The amount of gross negligence, incompetence and ineptitude demonstrated by senior management, Human Resources and front line supervisors is appalling! I would like to see admonishments, suspensions, demotions or outright removal from their positions all that allowed this abuse to continue for 6 months and could have resulted in the suicide of a Veteran. I would like to see these penalties enacted to send a message to others in a position of authority. The message has to be when the evidence is overwhelming and there is a danger to a patient the VA will err on the side of caution and remove the employee pending the outcome of the investigation. We can and should do better when it comes to the safety of our patients.

I feel that the partially substantiated allegation #2 should be changed to substantiated and those responsible for the mental anguish and physical distress placed upon the patient should be held fully accountable.